Liverpool Heart and Chest Hospital NHS
NHS Foundation Trust

Quality Strategy

2017 - 2020

Excellent, Compassionate and Safe care for every patient, every day

Contents

*Our vision **to be the best** - delivering and leading outstanding heart and chest care and research.*

Context of the Strategy

In June 2017 I presented the refreshed Quality Strategy which set out our aspirations for the next three years. The strategy described our journey of continuous improvement and our ambition to deliver our mission of excellent compassionate and safe care, for every patient every day.

The first year of the strategy was largely focused around progressing our key priorities and forward planning the priorities for 2018, whilst continuing our focus on remaining an 'Outstanding Trust'. This refreshed version of the strategy, details improvements made and those priorities taken forward into 2018-2019.

We have seen significant improvements in organisational culture over the last 12 months, with the adoption of the 'Listening into Action' approach re-energised from April 2018. This has involved a major focus on frontline staff engagement to make the changes that will enhance care to patients and families. To sustain this momentum, we are continuing to develop and support further waves of improvement in clinical safety, quality and service this year.

Alongside this we have focused on developing a culture of being open, honest and transparent with our patients and their families and our Freedom To Speak Up vision and strategy is the cornerstone for the culture of openness and transparency for our staff. Quality of care is at the heart of everything we do, and this is supported by a welcoming, honest and compassionate approach to our delivery of health care. We will continue to engage with our patients and families in order to improve our services whilst learning from incidents and errors. We will strive to deliver excellent healthcare, whilst supporting our staff to speak out safely, to reduce avoidable harm.

This Quality Strategy brings together the learning from the Francis Report, the Keogh Report and the Berwick Review with the Trust's own programmes of work, for example our Sign up To Safety pledges, Listening into Action and Service Improvement, to ensure a cohesive approach to maintaining safe quality care provision.

The role of Liverpool Heart and Chest Hospital (LHCH) across the health economy is important in addressing the quality and safety of care for patients. LHCH continues to develop strong partnership work across the region. As Chief Executive, I am the Senior Responsible Officer for the Cardiovascular Disease (CVD) Programme in the Cheshire and Merseyside Health and Care Partnership. Some of our clinicians have been leading on important pieces of work with a regional impact, looking at the standardisation of care pathways and service re-design, and the Trust is a pivotal player in the Liverpool City Region health plan. The One Liverpool plan has a number of priorities on cardiovascular and respiratory conditions which are clinically-led by LHCH.

From this partnership work we have seen significant achievements, such as the publication and approval of 8 cases for change aligned to the priorities of the CVD programme; including pilot work with Southport and Aintree Hospitals to improve the access to primary pacing services to enhance the quality of care to these patients.

There is a big focus on prevention of CVD in the North of England; I am a key member of a taskforce leading the development of a framework for CVD prevention across the regions in the North, which will be rolled out nationally.

Context of the Strategy

The partnership work is now looking towards the future, and we are already planning new programmes of work on other cardiovascular conditions to further improve the quality of care for our population. Infective endocarditis and mental health conditions will be some of the new work streams taken forward.

At a local level, the Trust is leading on the development of a single cardiology service for the city of Liverpool, working in collaboration with our partners at Aintree and Royal Liverpool and Broadgreen University Hospitals.

The core elements of this Strategy remain:

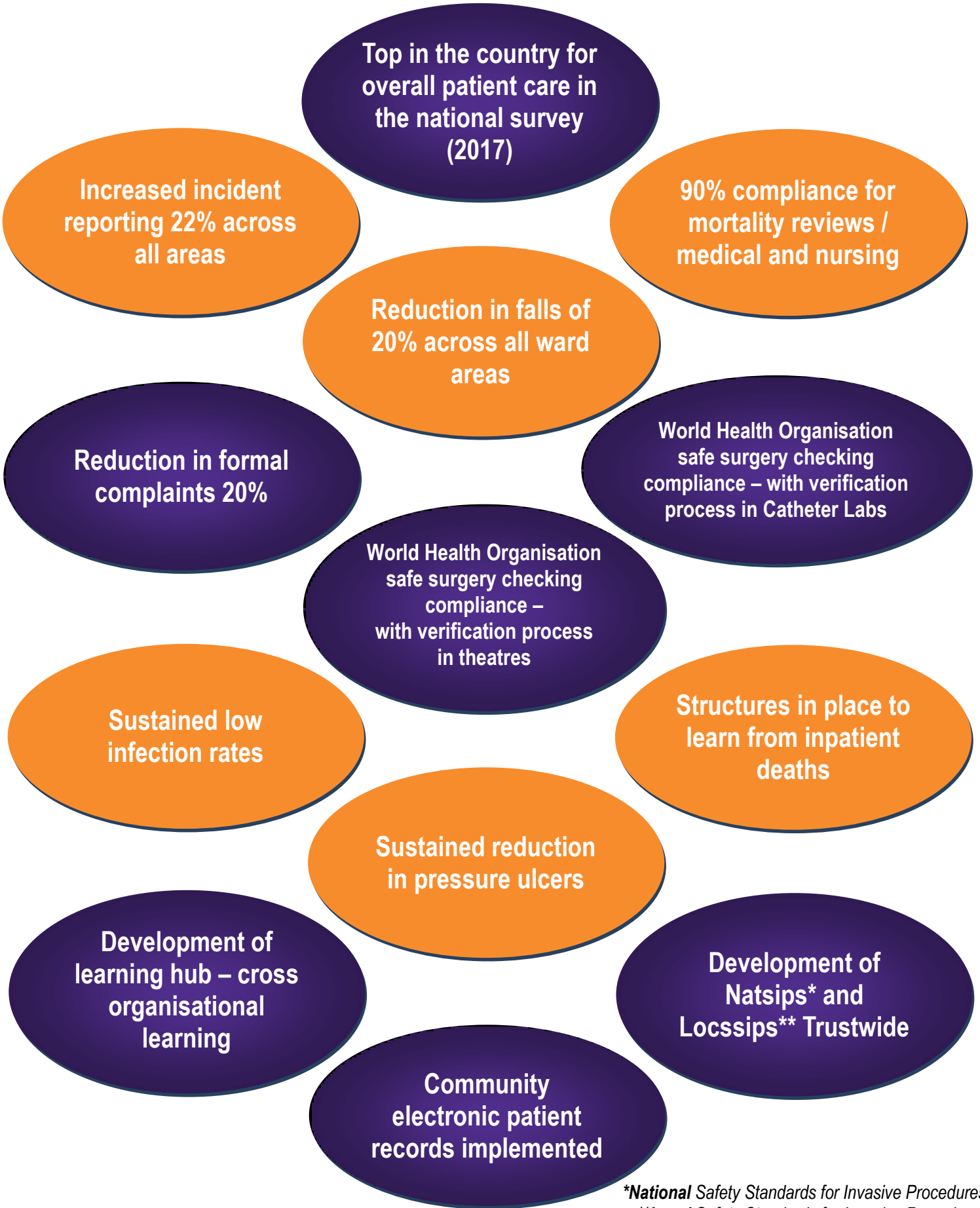
- **Patient safety**
- **Patient and family experience**
- **Clinical outcomes and effectiveness**
- **Regulation, compliance and assurance**

This document is closely aligned to our Trust quality accounts, quality priorities and the Care Quality Commission domains - safe, effective, caring, responsive, and well led.

Our approach to quality supports our overall vision *'To Be the Best'* with patient outcomes reflective of the best evidence based care. This Quality Strategy brings the core elements together in one refreshed comprehensive document.

Jane Tomkinson, OBE
Chief Executive

Looking back
Our progress in 2017/18



*__National__ *Safety Standards for Invasive Procedures*
**__Local__ *Safety Standards for Invasive Procedures*

Defining Quality and Governance

Liverpool Heart and Chest Hospital (LHCH) strives to deliver a model of care that is underpinned by safety, quality and value for money, with the patient and their family truly at the heart of everything we do. Our desire to achieve excellence is supported by our vision: '***to be the best - delivering and leading outstanding heart and chest care and research'.***

Our approach to care recognises patients deserve their individual care needs assessed and met by a highly skilled workforce. This approach encourages families and carers to be part of care giving, thus also working jointly with healthcare teams to deliver a truly excellent hospital experience that they would wish for others.

Our staff are empowered to make decisions which will enhance care for patients and families – they are not required to seek permission. This results in examples of care where our staff consistently go above and beyond to meet the care needs of our patients and families.

Our six steps patient and family experience vision sets out the patient and family journey and our expectations for their experience. We measure the outcomes of this each month to be sure that we are meeting these expectations.

What we are trying to achieve?

Our ambition is to create a culture of continuous improvement and empowerment that is both patient and family centred and safety focused. We will continue to:

- **Listen and act on feedback from our patients, their families and staff**
- **Work with our stakeholders, listening to their views and acting on their feedback**
- **Develop our values and behaviours by involvement of all staff**
- **Focus on human factors – how we deliver care within our teams**

Quality Governance is defined as encompassing three equally important elements:

Care that is safe

...by reducing mortality and harm

Care that is clinically effective

...by providing reliable care and reducing variation

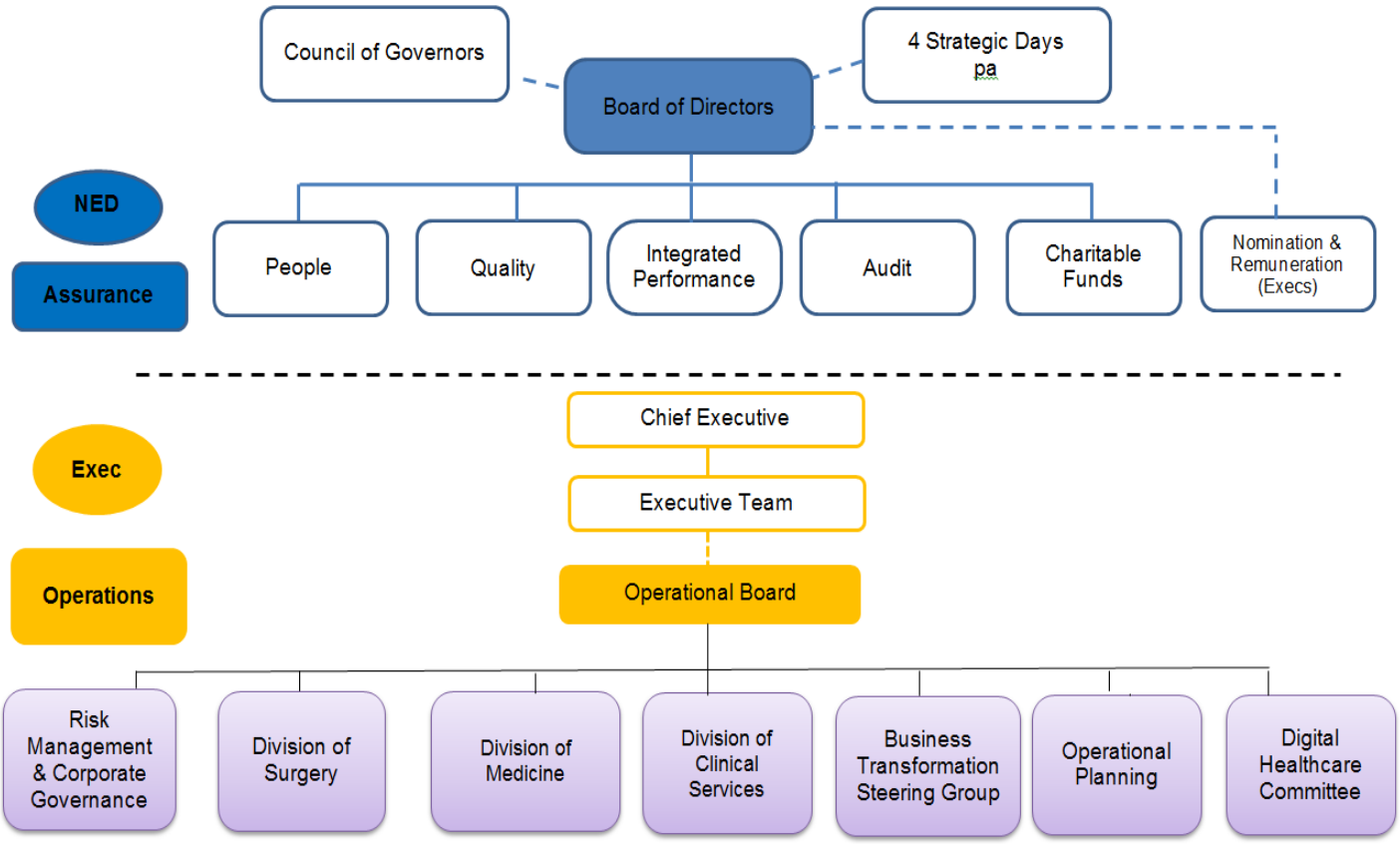
Care that provides a positive experience for patients, families and care providers

...by improving patient and staff experience

Quality Governance Committee Structure

Quality Governance is the combination of structures and processes at and below Trust Board level.

At LHCH these include:



Our Freedom to Speak Up Vision and Strategy

Freedom to speak up is the foundation on which our safety strategy is built. Our Quality Governance Strategy is based on continuous improvement actions, which are intrinsically linked to our longer term corporate vision ***to be the best- delivering and leading outstanding heart and chest care and research.***

Our principles for safety

Encouraging our staff and patients and families to speak up when they have concerns that may impact on safety

- Promotion of our hospital values and behaviors
- Triumvirate quality streams within and across the divisions
- Triumvirate accountability for quality and continuous improvement
- Divisional responsibility for clinical effective care
- The use of analysis and quality data to drive improvements and divisional performance

In order to truly embrace safety, **our safety seven model** is embedded in to every day practices. This information gives staff the platform to own patient safety and drive safe care delivery for every patient.

Our Freedom to Speak Up Vision and Strategy

What we want to achieve

- Continue to promote a culture of safe care with reduction of clinical errors and adverse events
- Improvements in the patient and family experience with excellent outcomes with a focus on reduction of variation with measurable improvements in quality of care
- Have an open and honest hospital where safety is at the centre of care and where HALT becomes the vehicle for staff to prevent harm occurring for patients and/or staff
- HALT is a method that or staff and patients can use to prevent harm
- Safe evidenced and effective care that adheres to best practice
- Listen to patient and family feedback, put in place measurable quality actions for improvements required
- Clinical leadership within the divisions with focus on development of clinical and non-clinical teams. Having the right skill and staff in the right place and at the right time for patients
- Adapt to the changes in healthcare needs – encompassing seven day working.

Our PACT

A Trust's culture is driven by the values and behaviours of its people. Staff at LHCH have identified the values and behaviours they feel are essential to delivering our vision. These are summarised in our PACT.

- We will constantly provide the best possible standards of compassionate care.
- We will develop a behavioral standard framework created by our staff that gives a clear picture of expectations aligned to our performance process within My PACT.

Quality Teams

There have been a number of improvements made to strengthen Divisional leadership to provide support and leadership to the operational management teams.

Clear roles of responsibility and accountability are reflected in the triumvirate teams. These teams lead their clinical services and comprise:

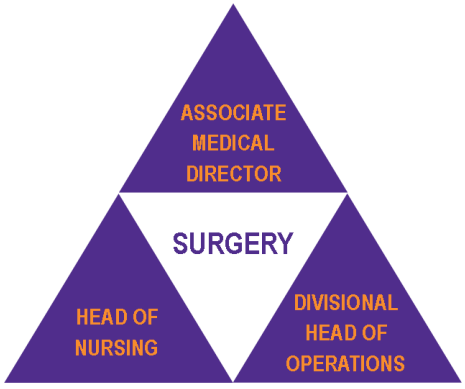
- an associate medical director
- divisional head of operations
- divisional head of nursing and quality.

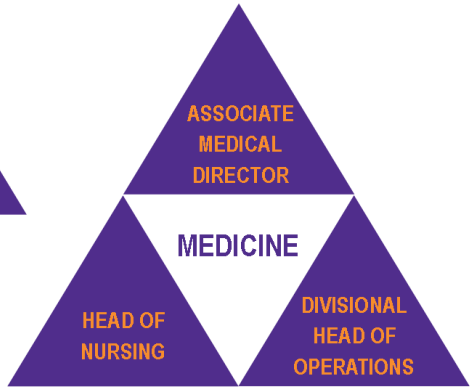
This supports the Trust's objective of integrated governance from ward to Board.

The divisions have reviewed their quality priorities for the forthcoming year and many of these are reflected in the Trust objectives. In addition, there are other key quality improvements that the divisions have set as priorities for 2018/2020 that are pertinent to their own division.

Dr Raphael Perry
Medical Director and
Deputy Chief Executive

Sue Pemberton
Director of Nursing
& Quality





Human Factors

Using human factors to understand and improve how we behave and interact with others will help us continually improve for the benefit of our patients and staff and make our hospital as safe as it can be.

We have invested in developing Human Factor champions and through work based simulation which re-enact situations to help us understand and change practice to prevent incidents re-occurring. Commitment from staff to attend meetings and training has proven essential in taking the human factor agenda forward.

The Trust will appoint two medical leads to lead a programme of simulation for the Trust to be used to identify how human factors in difficult and or stressful situations can impact on safety. The learning from the simulation exercises will be fed back into the Trust's learning hub.

HALT

The Trust has implemented the HALT which is used regularly across the Trust. This will remain a priority for the Trust as a means of preventing incidents and ultimately harm to patients. The Trust will monitor monthly the number of HALTs raised each month and look to increase them in each of the next two years.

HALT for Patients and Families

The HALT has been implemented for patients and families' however instances of its use needs to increase. The Human Factors group needs to drive performance with HALT for patients and families by empowering them to use this if they have concerns that their care and treatment is not as it should be. This will have benefits both in preventing harm and reducing complaints.

Human Factors

Incident Reporting

The Trust has improved its incident reporting rate over the past three years. An increase in reporting is suggestive of an improving safety culture. The Trust will aim to increase its incident reporting rates by 5% each year.

The recording system, Datix, does allow for the recording of HALTs although staff feedback is that the categories on the system need review. The Trust will review the way in which it captures HALTs through its incident reporting system. The Human Factors group will review and analyse the themes within the HALTs reported and extract the learning for feedback through the Trust's learning hub.

Freedom to Speak Up (FTSU)

Effective speaking up arrangements help to protect patients and improve the experience of staff. Having a healthy speaking up culture is an indicator of a well-led trust.

LHCH launched FTSU and has had a FTSU Guardian in post since September 2016.

A FTSU Policy, aligned to the national whistleblowing policy is in place and in May 2018, NHSI and the National Guardian's Office published new guidance for Boards on FTSU in NHS trusts and foundation trusts.

Trust-wide Safety Huddle

All groups of staff attend our daily Trust-wide safety huddle led by the Chief Executive where areas of risk and potential safety concerns are shared. This then cascades into safety huddles within departments and wards with clinical teams sharing and discussing how to ensure safety for our patients.

Quality Improvement Programme

Liverpool Heart and Chest Hospital's quality improvement programme for 2018-2020 aims to examine its current processes and systems; to better understand where value is added or waste is present and then refine the process or system to deliver all or some of the following:

1. Improve staff, patient and/or family experience in line with the Patient and Family Experience Vision

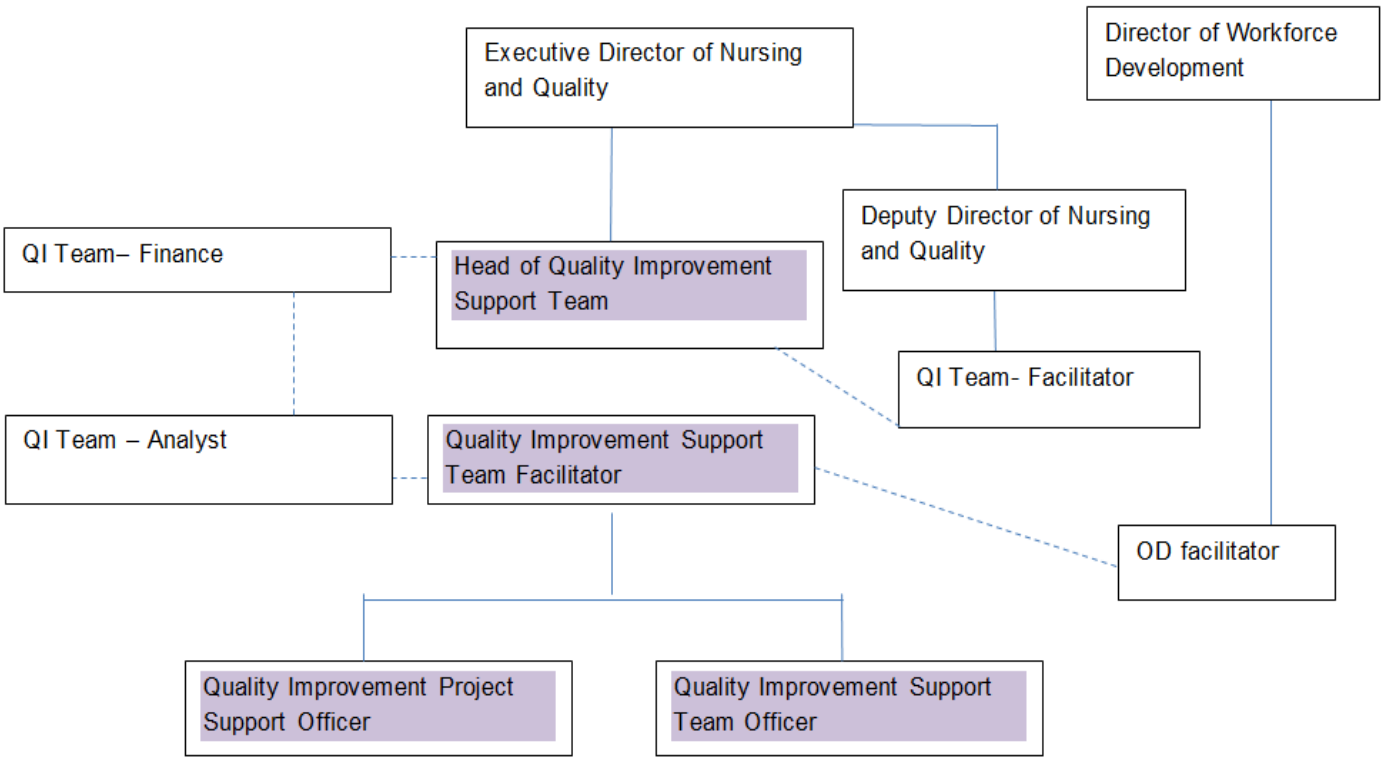
2. Reduce errors and improve quality

3. Improve efficiency (time and money)

Our strategy of engaging staff, to take forward the concept of quality improvement is by the utilisation of a range of tools and techniques that can be used together or in parts to measure, analyse and implement improvements.

Our framework provides an overview of the function of Quality improvement at LHCH, roles and responsibilities of all members of the team, Listening into Action (LIA), A3 thinking, governance and reporting requirements.

Team Structure



Quality Improvement Approach

The approach that has been developed aims to bring together cost, quality, service and quality improvements and Innovation.

Quality Improvement Programme

Listening into Action (LiA) improvement approach

On completion of a pulse check survey, suggestions for an improvement opportunity to facilitate further engagement within the Trust was identified. The Trust made the decision to implement the LiA seven steps to progress them. The LiA seven steps to improvement is a lightly structured, common-sense approach that facilitates teams to progress their ideas through A3 methodology.

A3 Methodology

A3 reporting is a method used to support the more complex quality improvement work. A3 reports provide a standardised method of communicating a project of improvement within the Trust as they are easily recognisable.
The origins of A3 thinking (Institute of Healthcare Innovation) lie in Toyota manufacturing, and are part of the Lean methodology.
The A3 methodology also follows a 90-day cycle of improvement from the improvement project proposal to its conclusion. Using 90-day cycles of change enables the project teams to break actions down into manageable chunks. It allows flexibility, for the teams to work on key themes in parallel and help to maintain project momentum.

Quality Improvement Support and Training

The LIA team are working with the Trust, in its implementation of the seven steps to improvement, and a number of LIA sessions have been held. A toolkit for teams is being utilised to guide and support teams through their improvement through 2018-2019.

Governance

All improvements either through LIA or A3 will be tracked or reported by the Quality Improvement Support Team. The Clinical Divisions will use their performance and governance proformas to review improvement project progress, and provide a summary report to the Quality Improvement Steering Group monthly.

Each division will identify which improvement cycle they will be apportioned to, who will be leading the project and the team that will be supporting the improvement. The programme of work will be scheduled by the QI team, monitored by the Quality Improvement Steering Group, and the Quality Improvement Support Team will provide 'hand-holding' support for the relevant quarter's priority projects.

Showcasing Quality Improvement

A number of the priority improvement projects (A3) will feature each 90 day cycle on the 'Improvement Wall'.

The Improvement Wall is a display of the Improvement projects and their progress. This will allow the Executive team to review progress made, ensure that any risks/issues are mitigated/resolved, and empower the project teams to deliver improvement.

Quality Improvement Programmes

Our focus on quality objectives for 2018/19 is described in the tables on page 18-26. These tables incorporate both Listening into Action and service improvements.

How will we Measure Progress?

Progress against the quality improvement targets will be measured though the Trust's governance systems.

The Quality and Patient and Family Experience committee will be responsible for monitoring progress against the set quality improvements and will provide assurance to the Quality Assurance Committee and the Board of Directors on progress. Progress against the improvements will also be presented to the Council of Governors.

The Trust's Operational Board will monitor exceptions to achievement of the quality improvements and the divisional teams will manage these exceptions and address them to ensure that the quality, safety and experience of patients is not compromised.

The delivery of high quality, safe care along with an exceptional patient and family experience lies at the heart of Liverpool Heart and Chest Hospital. This quality improvement strategy confirms our commitment to ensure this is achieved.

Appendix 1 - Corporate

Quality Objective	Outcome	2018-19 Target
Promote safety culture	Increase incident reporting	Increase by 10%
Reduce harm by improving the use of the HALT for staff	Promote Halt	To advertise and promote the HALT To record the number of HALTS and carry out a thematic review after each six month period Share the leanings through the learning bulletin Recognise the individuals that utilise HALT to outline their contributions to patient safety
Reduce harm by improving the use of the HALT for patients and families	Promote Halt for patients and their families	To promote the HALT for patients and families To record when and where the HALT is used Complete a thematic review each year of the strategy
Improve the safety culture by strengthening the freedom to speak up processes across the organisation	Promote safety culture	To complete the self-review tool issued with the publication (May 2018) and develop an action plan To develop a vision and strategy for FTSU, through engagement with staff To review and develop mechanisms in place to develop, promote, learn from and monitor FTSU activity To establish a Quarterly Summit to triangulate data to support learning and improvement towards achieving an open and transparent culture for speaking up To ensure wider engagement of the Board of Directors through a review of reporting and governance arrangements To continue to engage in regional and national FTSU networks
Reducing harm by reducing the number of falls by 10%	Promote safety culture	Successful reduction in falls of 19% in 17-18, and a further 10% reduction by end of March 2019
Reducing harm by ensuring that the sepsis bundle is utilised consistently	Promote safety culture	Steady progress being made in 2017-18 being 65%. Achieve 70% compliance with first antibiotic received within the one hour by end of March 2019 Care bundle fully operational by end of March 2019
Reducing harm by reducing the number of antibiotics prescribed	72 hour review for patients who are prescribed antibiotics	Reduction in antibiotic consumption by end of March 2019

Appendix 1 - Corporate

Quality Objective	Outcome	2018-19 Target
Improvement in patient experience by reducing the numbers of complaints	Reduction in clinical complaints specifically regarding clinical care	Reduce by 10% by end March 2019
Ensure that all patients with enhanced needs – learning disabilities, mental health, visual or hearing impairments, autism, dementia and any other disablement receive the right care at the right time in our hospital	Ensure that there is a clear process to identify patients with an enhanced need to enable the right care to be planned and in place to meet their needs when coming into out hospital	A full and comprehensive plan in place outlining the process for identification of patients' needs prior to admission and during their stay in hospital.
Improve administration processes to ensure that patients receive the right information at the right time prior to admission and after discharge	Bring together the admin functions trust wide under one admin team to ensure that all improvements to process and structures can be delivered cohesively	A service improvement project will commence in September 2018 describing the overarching improvements for the admin team .
Improve Trust-wide communications	To standardise the how and when of Trust wide communications to maximise how information is shared across the organisation	To be completed by April 2019

Appendix 2 - Medicine

Quality Objective	Outcome	2018-19 Target
Reducing harm by ensuring that Natssips and Locssips are embedded across the medical division	Audit of Natssips and Locssips will be completed and the actions identified for improvement	Audit implementation of Locssips by March 2019 Trust wide action plan in place. Formal update planned for QPFEC Nov 2018 Care Cube facilitating Locssip discussions in cath labs nationally. Need to encourage wider engagement between July and November 2018 for the wider teams with clinical leads.
Improve patient experience by involving patients and families in the nursing handover	All patients to receive a nursing bedside handover	To be established practice by end March 2019 All patients in medicine receiving a bedside handover. Care partner involvement is good and an area of focus for the teams. Medicine matron has meetings with all patients and families in over 7 days. Matron 'business cards' under development to ensure families are aware of this as an opportunity for escalation to resolve any concerns. This is being done in conjunction with the WM's and Patient & Family Support Manager.
Reducing harm by the delivery of effective and reliable care for NStemi patients	Implement pathway for direct NSTEMI patients	Pilot the new protocol this year for very high and high risk ACS admissions in October 2018 NSTEMI pathway improvement will be piloted from October 2018. The internal heart attack team are developing flow charts to operationalize the plan. Cross divisional engagement is underway. Presented at senior nurse business meeting July 2018. Scheduled for Governance, multi-triumvirate meeting and service line meetings throughout Aug and Sept. Engagement with critical care and anaesthetics will be scheduled following the process agreement with hospital co-ordinators.
Improvement in patient experience by reducing DNAS	Work with Head of Admin to review a corporate approach to managing appointments ie. text message / automation	Reduction in DNA in OPD clinics to ensure that the Trust is meeting regional target of 8.3%. A divisional action plan is in development: Audit of DNA reasons Access policy compliance Scoping of options to minimise DNA: text messaging, partial booking, telephone reminders, skype clinics Option to utilise DrDoctor online appointment management platform

Appendix 2 - Medicine

Quality Objective	Outcome	2018-19 Target
Reducing harm delivery of effective and reliable care by ensuring all eligible patients are referred for cardiac rehab	All eligible patients to be referred for cardiac rehabilitation	Review why patients do not attend and put actions in place to reduce – target is that 95% of appropriate patients are referred for cardiac rehab Competency documents developed for nursing staff with L&D. Lead nurse for cardiovascular disease services now implemented to ensure oversight of the CVD programme. Matrons in medicine and community CVD working collaboratively to improve the cardiac rehab service delivered within LHCH across both hospital and community.
To ensure that patient documentation is clear and concise and readily available for community patients	Implement electronic patient record	Full implementation and evaluation of EMIS by March 2019 Successful implementation from May 2018. This is being introduced one service line at a time to allow adjustments to be made to ensure patient safety.
Develop the EBUS/ Bronchoscopy service	To be a national leading exemplar in EBUS / Bronchoscopy	Develop a business case to outline investment in EBUS / Bronchoscopy aligned to the trusts respiratory strategy complete by June 2019. Respiratory team away day planned for 12th October 2018 to determine the vision for the service. Following agreement of respiratory priorities the BC can then be developed.
Review the pathway for PVI patients to look at admissions as a day case	Delivery of day case PVI	Pilot to commence this fiscal year. First PVI meeting planned 25th July 2018 to discuss approach. Complete by December 2018. Work has commenced on day case PVI. Numbers to increase to 4 x patients on Holly suite. (2 x morning patients per EP list). A3 underway
Upgrade the Cath Labs as per the capital plan	To be a recognised European reference site for best in class Cath Lab facilities for both patients families/carers and staff resulting high quality care / experience	Approved Business Case at Board September 2018 with an aim for implementation over 2-3 year period. Complete by 2021. Cath lab refurbishment plan due to go to board at LHCH September 2018. Communication strategy under development to ensure teams are clear about impact in the short term for the decant lab model.

Appendix 2 - Medicine

Quality Objective	Outcome	2018-19 Target
Reducing harm by ensuring that patients are not fasted inappropriately	Improve fasting compliance in the medicine division	Improve fasting compliance by 20% in the medicine division audit to review compliance Identify causes of non-compliance Aim to improve patients experience Audit data identified causes of non-compliance related to: • Letter accuracy (42% source of inaccurate information) • Information from staff (32% source of inaccurate information) • Patient choice (26% source of non-compliance) Action plan in place. Update to be provided to QPFEC November 2018.
Southport GP confederation expansion	Work with Southport DGH and the GP confederation to review the Cardiology support required and leadership available from LHCH partnership	Initial meeting to be held 31st July to explore this opportunity Opportunity to develop nurse led clinics in the community and further develop the HF service via the LHCH@model
Patient flow within medicine	Collaborative working across all teams	Review of capacity and demand Review of Holly suite scheduling Bed modelling Future cardiology services Review April 2019 A3s underway Review of Holly suite opening hours underway Review of the Birch ward model for step down and lounge required to support the NSTEMI service and OOH PPCI service Ward round to commence September 2018
Capacity and demand modelling: CG95 – To enable patients with stable chest pain to undergo FFR CT in place of an angiogram + or -	To avoid unnecessary procedures for this group of patients	To be reviewed by clinical services team – update April 2019 This is being clinically led and an A3 will be developed in collaboration with clinical services
CF Service – review the delivery of the CF service to evaluate its effectiveness and service delivery model	To ensure that the CF service meets the needs of patients for the future focusing on in and out of hospital	Review by Executive team November 2018 and implement changes by June 2019 Work has been completed to provide a service out of hospital for intravenous medications. The further review of the whole service has begun.
ACHD service	To ensure that the ACHD service meets the needs of patients and families	Review by executive team May 2019. NHSE review July 2019

Appendix 3 - Surgery

Quality Objective	Outcome	2018-19 Target
Reducing harm by ensuring that NatSSIPS and LocSSIPS are embedded across the surgical division	Audit of NatSSIPS and LocSSIPS will be completed and the actions identified for improvement. Trust wide Natssip action plan. Formal update to QPFEC November 2018.	Audit implementation of LocSSIPS by March 2019. Organisational LocSSIPS s to be written, implemented and audited by March 2019.
Improve patient experience by involving patients and families in the nursing handover	All patients to receive a nursing bedside handover at least once per shift Focus area is the lunchtime handover from early shift to night shift. This is the handover where the opportunity for families to be present exist, plus the longer handover period for staff.	To be 100% established practice by end March 2019 that all patients receive a nursing bedside handover that involve patients and families.
Reducing Harm by ensuring that patients are not fasted inappropriately	Improve fasting policy compliance by 20% within the surgical division. This includes compliance with fluid and food fasting Q1 Fluid fasting compliance is 75% and food fasting compliance is 77%. An increase of 20% would enable a compliance of 90% for fluid fasting and 92% for food fasting compliance. Fasting Action plan in place.	Focus for improvement - Surgical wards December 2018
Reducing harm delivery of effective and reliable care by understanding why and how surgical site infections develop and impellent a systematic process for collation of this data	Reduce the incidence of Surgical Site infections Surgical Site Infection Group MDT Bacteraemia review process Current surgical site infection average monthly rate 5-6%. This includes superficial wound infections. Scope Gold standard of wound surveillance follow up of patients once discharged.	Focus for improvement - Surgical wards and Surgical Site Infection Group December 2018
Reducing harm delivery of effective and reliable care by improving the care and management of patients with an NG tube	Eliminate all incidents pertaining to NG management Robust NG Management Action plan. Training and Development of Staff NG management competencies Revised NG policy.	Focus for improvement Surgical wards December 2018
Delivery of effective and reliable care by improving the numbers of patients who are admitted for surgery on the same day as procedure as outlined in the GIRFT report.	Implement SDA for all elective patients Aspen Suite opening on the 30th July 2018. Trial of DOSA throughout June and July with increasing numbers. Standard operating procedure and Operational Plan agreed and implemented.	August 2018

Appendix 3 - Surgery

Quality Objectives	Outcome	2018-19 Target
Delivery of effective and reliable care	Increase 10% of patients who are discharged by 12 midday on the day of discharge This will be in conjunction with the Surgical Inpatient Care model priority and the CUR A3	March 2019
In-Patient care model	To reduce variation on pathways & decrease LOS and increase early mobilisation and embed enhanced recovery Standardised Care with planned date of discharge. Led by surgical matron and Lead Advanced Nurse Practitioner. Divisional Service Improvement project.	Focus for improvement - Surgical wards December 2018
Theatre scheduling	Improved scheduling of lists and improved co-ordination of critical care requirements This work is incorporated as part of the Theatre Development work plan.	Focus for improvement - Theatre Dept December 2018 Reduction of cancelled operations Improved theatre rostering resulting in reduced bank/overtime Increased staff satisfaction.
Discharge delays by improving social work referrals	Reduction in the number of inappropriate referrals to Social worker team Devise new referral template Improve patients expectation and understanding of Social care Reduction in delayed discharges awaiting Social care input. Focus Group - OT/Social Worker/Discharge Team commenced. Inappropriate referral audit underway. A3 to be presented as part of LiA.	Focus for improvement - Surgical wards December 2018
7 day surgery Critical Coronary Disease and location of patients	Urgent Standard Operating Procedure states that 100% of urgent patients with critical coronary disease will be operated on within 7 days of being medically fit. Monitored and reported weekly by the SLM for Surgery.	Current Standard Practice. July 2018
Inventory Management	To have an efficient and effective stock and equipment management system and process to ensure the safe delivery of all surgical procedures while delivering efficiencies.	Focus for improvement - Theatre December 2018 Business Manager Secondment in place to enable progress. Review and realignment of roles and responsibilities within the stock and equipment team

Appendix 3 - Surgery

Quality Objectives	Outcome	2018-19 Target
Access to Education and Development	All staff to have access to learning, education and development in a manner that suits their individual needs.	**Focus for improvement Surgical wards December 2018** Trusts wide Improvement priority. All staff the opportunity to attend a Big Conversation to ensure the Trust's Learning and Development strategy meets the needs and requirements of the end user Identified pathways of progression Long term reduction in staff turnover Engagement from all areas of staff working in collaboration with the L&D team.
Review Shift patterns in Surgery	To review and if appropriate implement, a shift pattern that enhances staff's work life balance while promoting service delivery and increasing - roster efficiencies	**Focus for improvement Surgical wards December 2018** Working with the E-Roster team to review a variety of shift patterns. Review of the current shift patterns throughout the Trust

Appendix 4 - Clinical Services

Quality Objective	Outcome	2018-19 Target
Reducing harm by ensuring that all standard operating procedures are in place for Natssips and Locssips	Completion of standard operating procedures for Locssips. There is a Trust wide formal action plan.	Audit of compliance to be undertaken on the standard operating procedures in February 2019.
Delivery of effective and reliable care to ensure that medicines are reconciled appropriately for all patients	Develop a robust process to ensure medicines reconciliation occurs when there is patient movement between care areas, to reduce waste and duplication of medications. This is currently being developed into an A3 improvement plan. This will be presented in September to the service improvement wall.	This is one of the divisions key areas for Service Improvement.
Reducing harm delivery of effective and reliable care by reducing the numbers of readmissions to critical care	To ensure that all patients are safely discharged to the ward areas from critical care and that all readmissions are subject to review and evaluation. A task and finish group has been developed and the first meeting has taken place. There is a robust action plan now in place. This will be monitored by governance committee.	Reduce level of avoidable readmissions to critical care by 20%
Reducing harm delivery of effective and reliable care by extending the anaemia service	To fully roll out extended Anaemia service. Anaemia Nurse to attend NMP in September. This will fully support the new service moving forward. A review of lessons leaned to date is currently underway.	To develop a fully working service by the end of March 2019.
Support the redesign surgical inpatient care model	Implementation of SDA for all elective patients who meet the criteria SDA - Aspen Suite planned to open end July.	To ensure robust process in place. That all patients who meet the criteria for SDA are facilitated.
Improving the Outpatients experience	To fully roll out the use of the KIOSK TV screen programme by end of Quarter 2. Introduction of front of house health care assistant . The redesign of pathways for patients with additional needs following a complaint. TV screens - due to go live 6th August. HCA out to advert	To ensure a robust process in place for the use of patient call system via TV screens monitored by the Outpatients survey. Front of house HCA in place to support new ACHD service and use of LAMP as an OPD facility.